ADH COVID-19 IMMUNIZATION CONSENT FORM

For COVID-19 Provider use only Clinic Name/Code:			
Location type:(clinic, health department, pharmacy, etc.,)Address:City:State:Zip Code:Date of State:			
Address:City:	County:		
State:Zip Code: Date of s	Service:		
Person Receiving Vaccine:			
(Logal) First Name: MI: Lost Name:			
(Legal) First Name: MI: Last Name:			
Date of Birth:			
4 MEDICAL MICEODY C. LA ALBERT			
1. MEDICAL HISTORY: Complete the following quest		vaccine.	
If you answer "YES" you may not be able to receive the C			
*If YES and further guidance is need of Health, Immunization Section @ 5		*YES	NO
Have you had a previous COVID-19 vaccine? If yes, date?	01-557-0707		
Have you had any vaccines within the previous 14 days? Pfizer-Bio	NTech or Moderna COVID-19 vaccine		
should be administered alone with minimal interval of 14 days before or after any other vaccine.			
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in			
isolation? Are you currently in quarantine for known exposure to C			
Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or injectable therapy? (including Pfizer-BioNTech or Moderna COVID-19 vaccine) Such as difficulty			
breathing, swelling of your face and throat, fast heartbeat, bad rash	· · · · · · · · · · · · · · · · · · ·		
weakness.	an over your body, dizzmess and		
Are you pregnant, breastfeeding or planning to become pregnant? V	Vomen in this group may receive Pfizer-		
BioNTech or Moderna COVID-19 vaccine, a discussion with your			
informed decision.			
Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe			
obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive Pfizer-BioNTech or Moderna COVID-19 vaccine unless otherwise			
contraindicated.	-1) vaccine unless otherwise		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Pfizer-			
BioNTech or Moderna COVID-19 vaccine should be deferred for at least 90 days to avoid interference of			
treatment with vaccine-induced immune responses.			_
NOTE: Depending on vaccine type, a second dose of COVID-19 v			
vaccine. Refer to your COVID-19 vaccination record card for seco Health Unit in 21 days or 28 days for more information. Keep your			
for proof of initial vaccine date.	vaccination record card for ye	our recore	10
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2. RELEASE AND ASSIGNMENT.	My signature below indicates I have read,		
Please read the section on the reverse side of this form.	understand and agree to section 2. Release and Assignment of the COVID-19 Immunization		
The Providers Privacy Notice is available at the clinic	Consent Form and Vaccine Recipient Emergency		
site or accompanies this form.	Use of Authorization Fact Sheet (EUA).		
Then sign in the box at right.	1		
Signature of Patient/Parent/Guardian:			
	J Signature of Fatienty Guardian.		
Dloogo sign horo			
Please sign here	Date		

RELEASE AND ASSIGNMENT: • I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for Pfizer vaccine visit the website www.cvdvaccine.com: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet. To read the Vaccine Recipient Emergency Use Authorization for Moderna COVID-19 vaccine visit the website https://www.fda.gov/media/144638/download or (modernatx.com) • I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine. • I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice. • I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization **Information System.** To My Insurance Carrier(s): • I authorize the release of any medical information necessary to process my insurance claim(s). • I authorize and request payment of medical benefits directly to this COVID-19 Provider. • I agree that the authorization will cover all medical services rendered until I revoke the authorization. • I agree that the photocopy of this form may be used instead of the original. **PATIENT INFORMATION:** ____ MI: ____ Last Name: ______ (Legal) First Name: Gender: Male Female Phone #: Date of Birth: Street Address: ______ P.O. Box _____ Apt. No. _____ ______ State: ______ Zip Code: 🗍 City: _____ **Race:** White Hispanic/Latino Black/African American Native American / Alaska Native Asian Native Hawaiian/Other Pacific Islander Other **INSURANCE STATUS (Check appropriate box):** Patient's Relationship to Insurance Policy Holder: Self Spouse Child Other Medicaid/ARKids Number: Medicare Number: Insurance Company Name: ___ Member ID/Policy #: REQUIRED POLICY HOLDER INFORMATION: (Legal) First Name: ____ MI: Last Name: Policy Holder Date of Birth: | / | | Email Address: _____ Policy Holder's Employer Name: COVID-19 VACCINE ADMINISTRATION (Completed by staff only) Refer to product-specific Emergency Use Authorization (EUA) fact sheet for COVID-19 providers Refrigerated COVID-19 Vaccine AstraZeneca **Ultra-cold COVID-19 Vaccine** Frozen COVID-19 Vaccine Janssen Pfizer-BioNTech Moderna Novavax-Matrix-M1 Other COVID-19 Vaccine **Site Code** Dosage mL MFG Code Route Lot Number IM MFG Codes: PFR=Pfizer-BioNTech, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA Signature and Title of Vaccine Administrator:

FORM 5427 Revised 01/04/2021

Date Vaccine Administered: / /